DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAR 8 1993

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject California: Review of Short/Doyle Medicaid Contract Rates for Fiscal Years 1985 through 1989 (A-09-92-00094)

To William Toby, Jr.
Acting Administrator
Health Care Financing Administration

This is to alert you to the issuance on March 10, 1993, of our final audit report to the State of California concerning Medicaid payments to counties with Short/Doyle contracts. A copy is attached.

Our audit disclosed that excessive Medicaid payments were made to these counties. The payments exceeded Medicaid limits by about $15 million ($7.5 million Federal share) over 5 years.

Short/Doyle is one component of the California Medicaid program. It is a special program serving the mentally ill, and is operated by the various counties in California which arrange for hospital and clinic services. In Fiscal Year (FY) 1985, the State began negotiating Short/Doyle contracts with selected counties. Initially, three counties received contracts. By FY 1988, 14 counties operated under this arrangement.

According to the State's Medicaid plan, payments to contract counties were limited to the lower of (i) negotiated rates, (ii) customary charges, or (iii) statewide maximum allowances. Even so, California did not apply the customary charge limits or maximum allowances to these counties.

State officials believed that the customary charge limit did not apply to these counties because they were providers with nominal fee structures. They contended that the counties charged fees for their services at less than 60 percent of their costs. Further, they contended that the rates were properly limited to the statewide maximum allowances during the contract negotiation process with each county. Therefore, they argued that no disallowance should be taken if actual reimbursement exceeded the amounts budgeted.

Based on the advice we received from the Office of the General Counsel, we believe that California's position was entirely inconsistent with the language of the State's Medicaid plan. We also concluded that the Federal Government should not pay a share of the costs which were paid in violation of the limits imposed by the State's plan.

We are recommending that the State refund the $7.5 million in excess Federal Medicaid funds paid to the counties and establish procedures to ensure that payments are properly limited in the future.

State officials did not agree with our finding and recommendations. However, regional Health Care Financing Administration officials concurred.

Attachment

For further information, contact:
Herbert Witt
Regional Inspector General
for Audit Services, Region IX
(415) 556-5766

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SHORT/DOYLE MEDICAID CONTRACT RATES FOR FISCAL YEARS 1985 THROUGH 1989

MARCH 1993 A-09-92-00094

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit
50 United Nations Plaza
San Francisco, CA 94102

MAR 10 1993

CIN: A-09-92-00094

Molly J. Coye, M.D., M.P.H.
Director
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814

Dear Dr. Coye:

Enclosed for your information and use are two copies of an HHS/OIG Office of Audit Services report, "REVIEW OF SHORT/DOYLE MEDICAID CONTRACT RATES FOR FISCAL YEARS 1985 THROUGH 1989." Your attention is invited to the audit finding and recommendations contained in the report.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HHS/OIG Office of Audit Services reports are made available, if requested, to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised.)

Final determination as to actions taken on all matters reported will be made by the HHS official named below. We request that you respond within 30 days to the HHS official named below, presenting any additional comments or information that you believe may have a bearing on his final decision.

Sincerely,

HERBERT WITT
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to:

Associate Regional Administrator
Division of Medicaid, HCFA
75 Hawthorne Street - 4th Floor
San Francisco, CA 94105

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EXECUTIVE SUMMARY

Excessive Payments on Contracts

Excessive Medicaid payments were made on Short/Doyle contracts entered into between California and 14 counties. The contract payments, which were used to fund mental health programs, exceeded Medicaid limits by about $15 million ($7.5 million Federal share) over 5 years.

Payment Limits Not Enforced

Although California had incorporated payment limits into its State Medicaid plan, these ceilings were not enforced for counties which had negotiated Short/Doyle contracts.

According to the State plan, Medicaid payments for contract counties were limited to the lower of (i) negotiated rates, (ii) customary charges, or (iii) statewide maximum allowances. However, California did not apply the customary charge limits or maximum allowances to these counties.

Federal Funds Overclaimed

Because the State did not enforce its own payment limitations, Federal funds were overclaimed. We are recommending that California (i) refund the $7.5 million in overclaimed Federal funds, and (ii) develop procedures to limit Medicaid payments under Short/Doyle contracts in accordance with its State plan.

Response to Audit

State officials did not agree with our finding and recommendations. However, HCFA officials concurred.

BACKGROUND

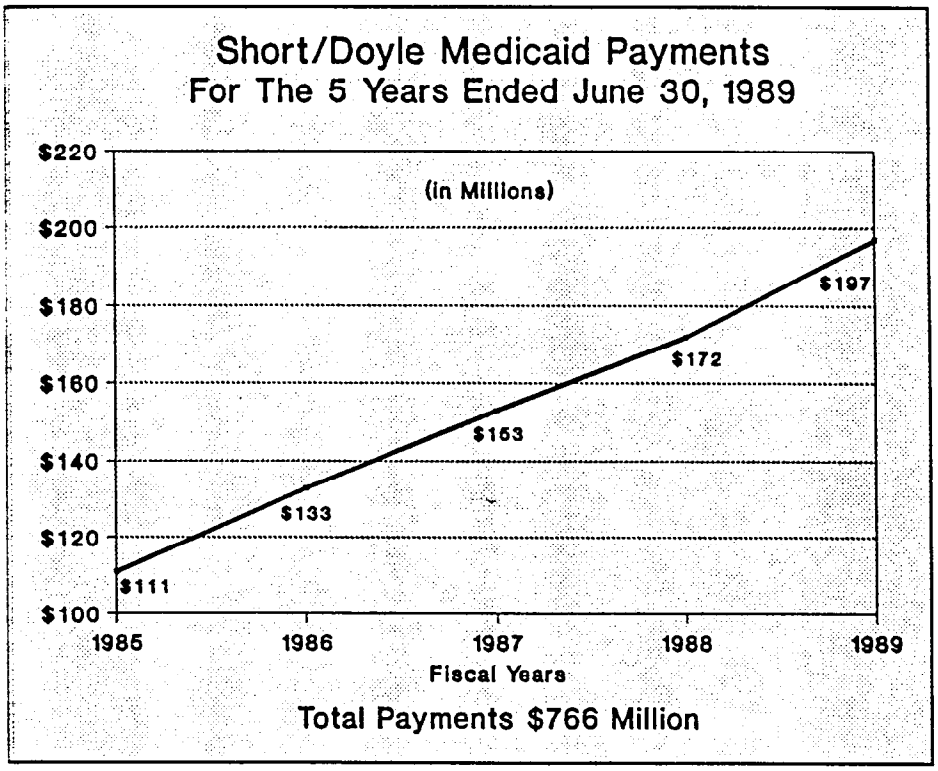
Medicaid Program

The Medicaid program, authorized under Title XIX of the Social Security Act, was established to pay for medical services on behalf of eligible low-income persons. The states arrange with medical service providers such as doctors, medical laboratories, pharmacies, hospitals, clinics, and other organizations to provide the needed medical assistance. The cost of the Medicaid program is shared by the Federal and the state governments.

California Short/Doyle

Established in 1971, the Short/Doyle program is one component of the California Medicaid program. It is a special program serving the mentally ill, and operated by the various counties in California which arrange for hospital and clinic services.

For the 5 fiscal years ended June 30, 1989, Short/Doyle Medicaid expenditures totaled about $766 million. The Federal and State governments each paid 50 percent, or $383 million.



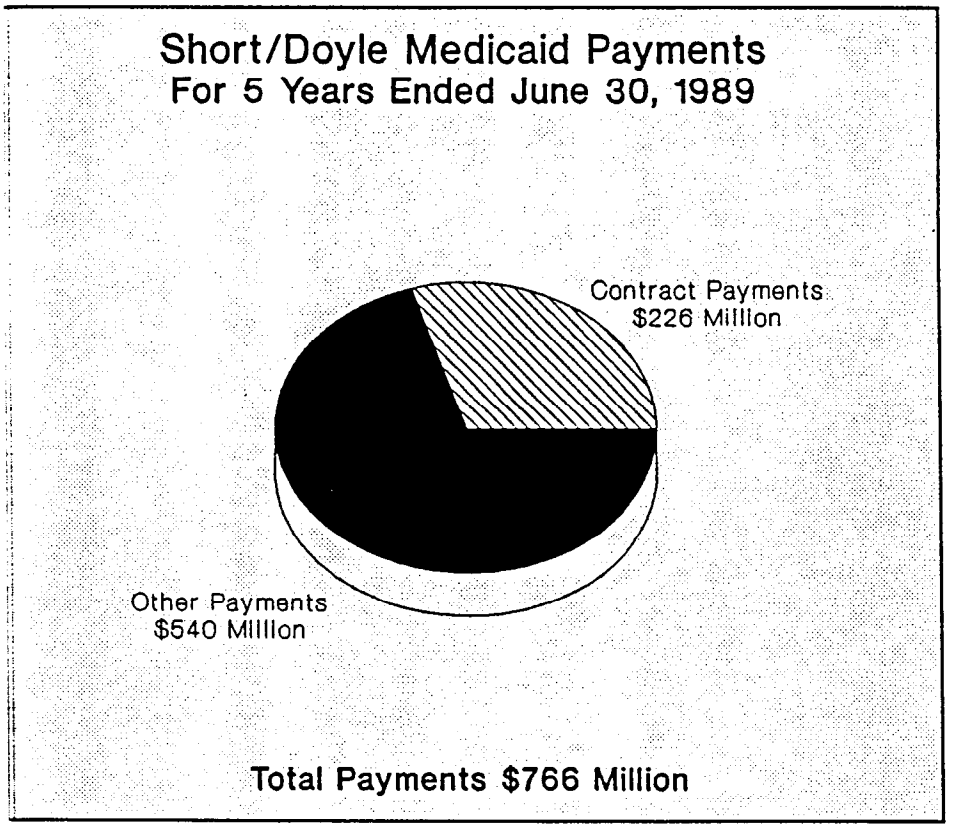
At the State level, the Department of Mental Health administered this program. The Department was responsible for negotiating contracts with the counties, setting the statewide payment limits, approving and paying the counties' claims, and monitoring the counties' programs to assure compliance with Medicaid requirements.

The Department of Mental Health reported the counties' claims to the Department of Health Services. As the single State agency, the Department of Health Services submitted them to the Federal Health Care Financing Administration (HCFA) for payment.

Short/Doyle Contracts

In fiscal year 1985, the State began negotiating Short/Doyle contracts with selected counties. Initially, three counties received contracts. By fiscal year 1988, there were 14 counties operating under this arrangement.

The 14 counties were paid $226 million, or 29.5 percent of the total Short/Doyle Medicaid payments for the 5 fiscal years ended June 30, 1989.



Federal Requirements

Section 1903(a)(1) of the Social Security Act (Act) states that Federal financial participation is available for funds expended for medical assistance in a manner approved in the state plan. Section 1902(a)(30)(A) of the Act mandates that the state plan must provide methods and procedures for the payment of care and services which will ensure that payments are consistent with efficiency, economy, and quality of care.

State Medicaid Plan Requirements

The California Medicaid plan limited payments for Short/Doyle services to the lower of:

1. Negotiated rates,

2. Usual and customary charges to the general public for the same or similar services,

3. Statewide maximum allowances for each service,

4. The provider's allowable cost of rendering the services, for those not contracting on a negotiated rate or negotiated net amount basis.

Prior Audits of Short/Doyle

We previously performed numerous audits of the Short/Doyle Medicaid program. We first compared the State's final claims under the program to costs reported by the counties for the 7 fiscal years ended June 30, 1989. We found that the State overclaimed $17.9 million of Federal Medicaid funds due to accounting and claiming errors. The State returned the amount overclaimed and implemented procedures to correct the system deficiencies.

We also reviewed the State's resolution procedures for overpayments identified by its audit section. We found that the State had allowed a large backlog of unresolved audit exceptions to accumulate over the years and had not refunded the Federal share. We recommended that the State promptly resolve this backlog and refund the Federal share of the overpayments. As of November 1, 1990, the State had refunded $13.4 million and was continuing to resolve other overpayments.

In a review of services billed to Medicaid in San Francisco County, we discovered that nearly one in every four claims was unallowable for Federal funding. We estimated that the improper claims

amounted to between $3.1 million and $4.9 million for the 2 fiscal years ended June 30, 1986. Claims were made for (i) unnecessary hospital care, (ii) services not documented, not provided, or lacking physician involvement, and (iii) duplicates. The State agreed to refund the Federal share of the improper claims and take procedural steps to correct the deficiencies.

In another review, we found that Short/Doyle payments rates exceeded reasonable limits established by Medicaid law and regulations. A detailed study in San Francisco County revealed that payments were 21 percent higher, or $3.6 million more, than the reasonable allowances under the Medicare program for the same services for the 2 fiscal years ended June 30, 1986. Also, the payments were 87 percent higher, or $9.5 million more, than the maximum permitted under California's regular Medicaid program. In response to this report, the State agreed to change its rate-setting methodology for the Short/Doyle program.

Finally, in a review of hospital care in San Francisco County for two years, we found that $658,000 of Medicaid funds were overpaid for mental patients who were treated in the hospital even though they needed only nursing care. The State paid over three times what Medicaid allowed in hospitals and nearly eight times what was allowed in nursing homes for this care. We recommended that the State (i) refund the Federal share of the overclaim, and (ii) limit payments to the Medicaid allowed amounts in the future. The State agreed.

SCOPE OF AUDIT

The objective of our review was to determine if payments to the 14 counties with Short/Doyle contracts exceeded Medicaid limits. Our audit covered the period July 1, 1984 through June 30, 1989, the most current fiscal years for which final claims were available at the start of our review.

In performing our review we:

- Analyzed the Federal law and regulations setting forth Medicaid rules for establishing payment rates;
- Reviewed California's Medicaid plan for reimbursement requirements for Short/Doyle services;
- Reviewed the State's policy letters and related correspondence regarding Medicaid payment requirements for Short/Doyle services;
- Performed a detailed comparison of the payments made under the contracts to customary charges and statewide maximum limits.

We also consulted with our Office of the General Counsel regarding the State's compliance with Medicaid requirements and the Federal authority to recover payments in excess of applicable limits.

Our field work was performed at the State Departments of Health Services and Mental Health in Sacramento, California and the HCFA regional office in San Francisco, California between August 1991 and August 1992. Our audit was performed in accordance with generally accepted government auditing standards.

We did not perform a study and evaluation of the State's system of internal controls because we concluded the audit could be performed more efficiently by expanding substantive audit tests, thus placing little reliance on the State's internal control structure.

In a later audit, we plan to determine whether payments to noncontract counties exceeded Medicaid limits.

RESULTS OF AUDIT

Our review of Medicaid payments to the 14 California counties which operated under Short/Doyle contracts disclosed that $15 million was overpaid for the 5 fiscal years ended June 30, 1989. The payments were 7.2 percent higher than allowed by the State's Medicaid plan.

Some counties were paid substantially more than allowed:

> **Fresno County was paid $5.5 million, or 31 percent more than Medicaid allowed;**
>
> **Riverside County was paid $2.4 million, or 22 percent more than Medicaid allowed.**

Although California's Medicaid plan limited payments to the lower of the provider's customary charges, or statewide maximum allowances, these limits were not enforced.

State officials believed that the customary charge limit did not apply to these counties because they were providers with nominal fee structures. They contended that the counties charged fees for their services at less than 60 percent of their costs. Further, they contended that the contract rates were properly limited to the statewide maximum allowances during the negotiation process with each county. Therefore, they argued that no disallowance should be taken if the actual reimbursements exceeded the amounts budgeted.

Because California's position was inconsistent with its Medicaid plan, we sought legal advice from our Office of the General Counsel. Based on the advice we obtained, we concluded that the payments in excess of the State plan limits were improper and a disallowance was appropriate. Therefore, we are recommending that the State refund $7,530,145 - the Federal share of these overpayments - and establish procedures to limit Short/Doyle payments in the future.

Payments Exceeded Limits

As shown in the following table, three counties received overpayments exceeding $2 million:

Counties	Medicaid Payments	Medicaid Limit	Amount Overpaid
Fresno	$ 23.0	$ 17.5	$ 5.5
Riverside	13.5	11.1	2.4
Santa Clara	58.1	55.8	2.3

(In Millions)

Three counties received overpayments in excess of 10 percent of their Medicaid limit:

Counties	Medicaid Limit	Amount Overpaid	Percent Over
Fresno	$ 17.5	$ 5.5	31%
Riverside	11.1	2.4	22
El Dorado	1.2	.17	14

(In Millions)

All 14 counties were paid more than the Medicaid limit, as shown in Attachment A. The overpayments in Santa Cruz, Stanislaus and Alameda were the lowest as a percent of their Medicaid limit.

Limits Not Enforced

California officials believed counties operating under Short/Doyle contracts qualified as nominal fee providers under Medicare regulations and were exempt from the customary charge limitation. They had State policy statements and legal opinions in support of their position.

Furthermore, these officials told us that they had applied the statewide maximum allowances during the contract negotiation process with the counties. Therefore, they believed that any payments in excess of the maximums should be exempt from an audit disallowance. They had a State policy statement instructing their auditors not to question payments in excess of the allowances.

Limits Were Required

Based on the advice we received from the Office of the General Counsel, we concluded that California's position was entirely inconsistent with the language of the State's Medicaid plan.

The customary charge limit applied to all Short/Doyle providers, including those that qualified as nominal fee providers under Medicare regulations. In addition, the statewide maximum allowances had to be used for calculating the payment of Federal Medicaid funds.

We concluded that the Federal government should not pay a share of the cost of those rates which were paid in violation of the limits imposed by the State's own plan. Further, we believe that the State needs to enforce its payment limits to reduce health costs for both the State and Federal governments.

RECOMMENDATIONS

We recommend that the State:

1. Refund the $7,530,145 of Federal Medicaid funds that were overpaid, and

2. Establish procedures to ensure that future Short/Doyle contract payments are limited to customary charges and statewide maximums in compliance with its Medicaid plan.

State's Response

In a written response dated November 23, 1992, the State disagreed with our finding and recommendations. State officials argued that California Medicaid regulations allowed for the consolidation of services under countywide average rates. They believed that, with one exception, they properly applied the statewide maximum allowances to the consolidated services during the contract negotiation process with each county.

The one exception was for hospital-based crisis intervention services. The rates for these services were allowed to exceed the statewide maximums because of the higher cost of providing such services at a hospital. State and county officials requested that we combine crisis intervention and individual therapy service functions for the purpose of our comparison to the maximum allowances.

State officials further argued that the contract counties were exempt from the customary charge limit because they were nominal fee providers. In support of their argument, the officials provided Medicare rules concerning this issue. The Medicare rules stated that nominal fee providers were entitled to payment of reasonable cost for their services.

California's response is included in its entirety as Attachment B to this report.

Auditor's Comments

We recognize that State Medicaid regulations allowed for the consolidation of services under countywide average rates. Nevertheless, the amount paid for the services exceeded the maximum allowed under Medicaid. The statewide maximum allowances were required to be applied to the amounts paid; not to the budgeted amounts in the negotiation process.

We also recognize that hospital-based crisis intervention services were costly. However, we limited Medicaid payments to California's statewide maximum allowance for this service. This maximum allowance was used by the State to limit Medicaid payments to noncontract counties for hospital-based crisis intervention services. In addition, the rates negotiated by the State did not combine crisis and individual services into a consolidated rate.

Finally, we believe that California's Medicaid plan required that payments to contract counties be limited to the customary charges and Medicare regulations did not apply. In addition, it should be noted that the State in practice did not follow Medicare regulations and limit payments to costs. Instead, it only used the regulations to waive its customary charge limit.

HCFA's Response

HCFA officials agreed with our finding and recommendations. HCFA's response is included it its entirety as Attachment C.

ATTACHMENT A

PAYMENTS IN EXCESS OF MEDICAID LIMITS

FOR THE PERIOD

JULY 1, 1984 THROUGH JUNE 30, 1989

Counties	Medicaid Payments	Medicaid Limit	Amount Overpaid	Percent Over Limit
Alameda	$ 44,248,305	$ 43,587,711	$ 660,594	1.5%
El Dorado	1,402,179	1,226,419	175,760	14.3
Fresno	23,036,463	17,565,795	5,470,668	31.1
Merced	5,444,971	5,024,541	420,430	8.4
Riverside	13,582,614	11,132,477	2,450,137	22.0
San Diego	41,977,302	39,995,797	1,981,505	5.0
San Joaquin	7,292,952	6,776,411	516,541	7.6
San Mateo	10,204,698	9,799,199	405,499	4.1
San Barbara	6,252,508	5,993,241	259,267	4.3
Santa Clara	58,161,788	55,850,858	2,310,930	4.1
Santa Cruz	2,126,310	2,103,820	22,490	1.1
Shasta	5,648,585	5,350,701	297,884	5.6
Stanislaus	5,911,765	5,835,724	76,041	1.3
Tehama	333,270	320,727	12,543	3.9
Totals	$225,623,710	$210,563,421	$15,060,289	7.2%

ATTACHMENT B

ATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

EPARTMENT OF HEALTH SERVICES
4/744 P STREET
O. BOX 942732
ACRAMENTO, CA 94234-7320
916) 657-1425

November 23, 1992

Mr. Herbert Witt
Regional Inspector General for Audit Services
Office of Inspector General, Region IX
Office of Audit
50 United Nations Plaza
San Francisco, CA 94102

DRAFT AUDIT REPORT CIN: A-09-92-00094 (DHS NO. 92-04)

Dear Mr. Witt:

This is in response to your September 15, 1992 letter to Molly Joel Coye, M.D., M.P.H., Director, Department of Health Services (DHS) which transmitted for review and comment a draft audit report entitled "Review of Short/Doyle Medicaid Contract Rates".

We have reviewed the draft audit report and provided comments in the format requested as shown below.

STATEMENT OF CONCURRENCE OR NONCONCURRENCE

The state does not agree with the findings and recommendations in this draft audit report.

REASONS FOR NONCONCURRENCE

We believe that the disallowances taken because the Medi-Cal reimbursement exceeded the maximum allowances promulgated yearly in Title 22, California code of Regulations (CCR), Section 51516, are not warranted. Those regulations established by the Department of Health Services (DHS) specifically allow for rates to be "based on a consolidation of existing service function categories" and "expressed and billed as countywide average rates". In the negotiating process the state, with one exception, did not allow any individual service function within consolidated category to exceed the maximum allowance for the service function. On a countywide basis, then, we dispute the audit findings.

The exception to the norm was the rate negotiated in some counties for hospital-based crisis intervention services, a process which seemed warranted because of the higher cost of providing such services at a general acute care hospital. The schedule of maximum allowances per service function category makes no distinction between hospital-based and clinic-based crisis intervention services. The counties which claimed for such services at the higher rate of reimbursement have requested the auditors to consider the regulations which allow for "consolidation" and "countywide average rates" and to combine crisis intervention and individual therapy service functions for the purpose of comparison to the maximum allowance. We support their request.

For each of the fiscal years of the audit period, DHS submitted to the Health Care Financing Administration (HCFA) as a state plan amendment, the Interagency Agreement (IA) with the Department of Mental Health. The provisions of Title 22, CCR cited above were included as an attachment and referenced under Section F, entitled Invoice/Claim and Payment Procedures.

We believe, also, that the disallowances taken because we did not apply the customary charge limits are not warranted. The opinion from the Office of General Counsel cited in the report seems clearly inconsistent with the provision of HCFA-15, Chapter 26 which states, in part:

> A provider with a no-charge or a nominal-charge structure will receive payment for items or services furnished Medicare beneficiaries based on reasonable cost. Only a public (now private as well) provider with a no-charge or nominal-charge structure, as defined in Section 2604.4 is exempted from the lower of cost or charges application. When a provider does not charge for services furnished, there is no basis for making the comparison and payment to such a provider will be the reasonable cost of providing such services. However, when a public provider imposes nominal charges for services furnished, a comparison of the provider's aggregate customary charges and aggregate reasonable costs (see Section 2614) shall be performed to determine the basis for payment.
>
> If the comparison substantiates the charges as being nominal, i.e., less than 60 percent of reasonable cost, a provider will be entitled to payment of the reasonable cost for such services. On the other hand, if the aggregate charges are determined to be other than nominal, the provider will receive payment based on the lower of its customary charges or reasonable cost.....

Additionally, since charges are the established amounts billed to the general public, the definition of the general public in HCFA-15, Section 2604.3, excludes those patients who were provided the services for which the federal reimbursement was claimed. General public is defined as:

> Those individuals not otherwise (a) eligible for coverage under Title V, XVIII, or XIX of the Social Security Act or local welfare program; (b) represented by a plan or agent under contract or agreement to make payments directly to the provider on a basis other than full charge; or (c) represented by a plan or agent under contract or agreement whereby the plan or agent rather than the patient is liable for payment.

The above contention is supported by an opinion written on December 14, 1990, by DHS, Audits and Investigation Unit (see Enclosure 1), which stated, in part, that Medi-Cal patients are not considered in the application of the formulas for the lower of costs or charges.

The IA also specifies, and has consistently specified, that for purposes of Section 51516, allowable costs shall be determined in accordance with 42 CFR (Part 405 and 413) and HIM (HCFA)-15 Principles and Standards.

In view of the above, we are requesting reconsideration of the audit findings.

Thank you for the opportunity and time extension granted to respond to the draft report. If you have any questions, contact Jose Fernandez, Deputy Director, Medical Care Services at (916) 657-5173.

Sincerely,

for
Molly Joel Coye, M.D., M.P.H.
Director

Enclosure

cc: Lynn E. Whetstone
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te of California — Department of Health Services

Memorandum

A-31
Lynn E. Whetstone
Deputy Director
Administrative Division
Department of Mental Health
1600 9th Street
Sacramento, CA 95814

Date: DEC 14 1990

m : Audits and Investigations
714 P Street, Room 650
Sacramento, CA 95814
445-2912

ject : Lower of Cost or Charges

We have been asked to once again comment regarding the application of the lower of cost or charges limitation (LCC) to Short-Doyle/Medi-Cal providers.

Our considered position is to first reemphasize the provisions of HCFA Publication 15-1, Chapter 26. This directs that reimbursement for services to Medi-Cal is limited to the lesser of reasonable cost of providing those services or the customary charges for the same services. HCFA 15-1 is very clear in pointing out that the charges billed to the program cannot be used to impose this limitation without first determining whether the billings to the program represent usual and customary charges imposed uniformly on patients liable for payment on a charge basis. If, after the application of appropriate tests, the billed charges are determined not to represent customary charges, then they must be adjusted in accordance with specified formulas.

Secondly, we will comment on two points of controversy which have arisen in applying the LCC for Short-Doyle/Medi-Cal reimbursement. These are:

1. Are straight Short-Doyle patients to be considered as being among those patients liable for payment on a charge basis (the general public)?

2. Is the Uniform Method of Determining Ability to Pay (UMDAP) a sliding scale charge structure which may, therefore, result in the provider qualifying for a nominal charge structure, and thus be exempt from the LCC?

We believe that straight Short-Doyle patients are effectively contractual patients that should not be included among those patients liable for payment on a charge basis. The Short-Doyle program amounts to a contractual arrangement between the State and a county, whereby the State pays the difference between the actual cost of mental health services and the amount collected by the county from patient and third party sources.

The State's payment is determined through a complex formula specified by the State and agreed to by the county. A county's total reimbursement is limited to an overall contract maximum.

The alternative view is to consider Short-Doyle patients to be members of the general public who are subject to the prevailing charge structure and any application of a provider's sliding scale charges. This leaves us with the problem of how to characterize Short-Doyle revenue. If it is not patient revenue it has to be characterized as a grant or donation, or perhaps even a subsidy payment similar to an infusion of county property taxes necessary to offset operating losses. This view though ignores the client specific nature of the Short-Doyle program. Admittedly, a county's Short-Doyle allocation is not tied to specific patients at the time of its initial calculation. However, a county receives no Short-Doyle reimbursement absent the delivery of service to qualifying patients. Furthermore, the State specifies the level of reimbursement for each patient, the method of billing, and reserves the right to audit. These restrictions seem more akin to a contract than a donation or a tax subsidy.

Furthermore, in considering the status of Short-Doyle patients it should be noted that Section 2604.3B.1(a) exempts patients eligible for coverage under "local welfare programs". This is in addition to the clear exemption granted title V, XVIII, and XIX patients. Short-Doyle may be considered under the umbrella of "local welfare programs". In this case Short-Doyle patients are clearly not to be included among those patients liable for payment on a charge basis.

From the discussion above one can see that the characterization of Short-Doyle patients for purposes of the LCC is not absolutely clear. However, the preponderance of information leads to the conclusion that they are effectively covered under a contractual arrangement which may also be considered a local welfare program. Therefore, they should not be considered as patients liable for payment on a charge basis.

The other issue in dispute was whether a county's UMDAP should be considered a sliding scale charge structure for purposes of applying HCFA 15-1, Section 2606.2D&E. All information presented us to this point indicates that UMDAP determines a patient's ability to pay as a function of income and family size. This seems to be the arrangement we typically characterize as a sliding scale charge structure. Section 2606.2D&E specifies various other conditions which must exist when considering a sliding scale charge structure in the context of the LCC. We have no information which allows us to comment on the application of these conditions to any specific case.

It had been suggested by DMH personnel that UMDAP was simply used to establish a patient's monthly share of cost obligation. This may well be the case. However, share of cost is a term applicable only to Medi-Cal patients. It refers to a beneficiary's monthly personal obligation that

must be satisfied before becoming eligible for Medi-Cal benefits. Medi-Cal patients are not considered in the application of the formulas for the LCC. Therefore, the application of UMDAP to Medi-Cal patients is irrelevant in terms of the LCC. Having disassociated UMDAP from Medi-Cal, its application to other patients must be considered as a sliding scale charge structure, provided the tests in Section 2606.2D&E are met.

We hope these comments help resolve this controversy. If we can be of any further assistance please do not hesitate to call me or Jeff Kemp at 2-8494.

Original signed by
EUGENE K. LYNCH

Eugene K. Lynch
Deputy Director

cc: Thomas E. Rietz
Deputy Director
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DEPARTMENT OF HEALTH & HUMAN SERVICES

ATTACHMENT C

Region IX
Health Care Financing Administration

Memorandum

Date: OCT 15 1992

From: Associate Regional Administrator
Division of Medicaid

Subject: Review of Short/Doyle Medicaid Contract Rates - CIN: A-09-92-C0094

To: Herbert Witt
Regional Inspector General for
Audit Services, OIGOAS

Refer to: MCD-F-RB
(FO-A-3 00094)

As requested by your memo dated September 15, 1992, we have reviewed the finding and recommendations contained in the subject audit report. We have met with Jim Kenny of your staff and agree with the conclusions made in the report.

If a disallowance becomes necessary for this issue, we will contact your staff to obtain whatever additional documentation, such as copies of selected working papers prepared by your auditors, is needed to support the disallowance.

Thank you for the opportunity to comment on this report.

Any questions concerning this matter may be directed to Rich Bortoli of my staff at 744-3562.

Lawrence L. McDonough